

I

PLEASE WRITE PLEASINLY, WITH UNFADING INK. Supply every item of information carefully. If no son or daughter, give age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

01021

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County

Baltimore

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Life

Hospital, institution, or street address where death occurred:

no

How long in hospital or institution?

no

3. (a) FULL NAME

Katherine Birmingham

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female A.A. Wigham

6. (b) Name of husband or wife

Henry Birmingham

7. Birth date of deceased (mo., day, yr.)

May 6 1889

(c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

58

-

-

hrs.

min.

9. Birthplace

Berlin, Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Same as above

12. Name

William E. Purcell

13. Birthplace

Berlin, Md

14. Maiden name

Jane Maney

15. Birthplace

Berlin, Md

16. Informant

Mrs. Magdalene Miller

Address

Philadelphia, Pa

17. Burial

Date thereof Jan 19 1948

(Burial, cremation, or removal. Which?)

(month)

(day)

(year)

Cemetery or crematory

New Berlin

Location

Berlin, Md

18. Funeral director

James H. Stewart

Address

Salisbury, Md

19. 1-19-

Date rec'd by registrar

19-

48

Helen S. Hayward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Baltimore

City or town

Berlin

Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

no

(If rural, give LOCATION)

2.(a) If veteran, name war

no

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH

1-14-48

19

at 9 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-11-48 19 to 1-14-48 19 and that I last saw her alive on 1-13-48 19

Immediate cause of death

Acute Int. nephritis

DURATION

Due to

Pneumonia, Bronchial

Due to

My pertussis

Other condition

Acute mental deterioration

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

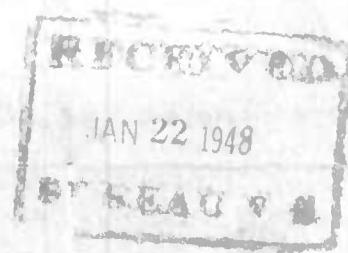
23. SIGNATURE

Olefford E. Schell

M. D. or other

Address

Berlin, Md Date signed 1-15-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01022

CERTIFICATE OF DEATH

1318
Reg. Dist. No. 355

1. PLACE OF DEATH:

County.....

City or town.....

Worcester
Shawell

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Life

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Daniel James Cathell

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widower

6. (b) Name of husband or wife.....

Annie Cathell

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age — years

April 29, 1960

8. AGE: Years

Months

Days

If less than one day

87 9 27 hrs. min.

9. Birthplace.....

(Town, county, and state)

Shawell

10. Usual occupation.....

Carpenter

11. Industry or business.....

Geo Cathell

12. Name.....

Geo Cathell

13. Birthplace.....

Md.

14. Maiden name.....

Sarah Finch

15. Birthplace.....

Md.

16. Informant.....

Norway Father

Address.....

Shawell

17. Burial, cremation, or removal. Which?.....

Feb. 2, 1948
Date thereof (month) (day) (year)

C.O.P.

Cemetery or crematory.....

Bushyville Md.

Location.....

Bushyville Md.

18. Funeral director.....

Mrs. Fasha Watson

Address.....

Lilysville Aly.

19. Date rec'd by registrar.....

1948

Helen F. Hayward

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

Maryland County Worcester

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Jan 31

1948 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from

19..... to 19.....

and that I last saw h..... alive on

Immediate cause of death.....

Chr. Myocarditis

DURATION

Due to.....

Due to.....

Other conditions.....

Chi-nephritis

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

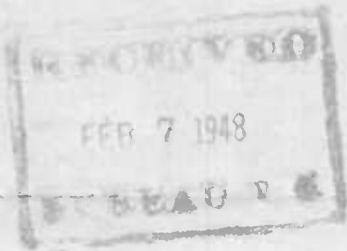
Means of injury.....

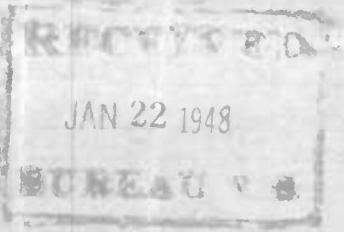
Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Chas R. Lee
Berlin Md. Date signed 2/8/48





PLEASE WRITE PLAINLY, WITH FADING INK. Supply every item of information carefully. If the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01024

CERTIFICATE OF DEATH

131a
Reg. Dist. No. 350

1. PLACE OF DEATH:

County.....

Worcester

City or town.....

Rural Locomoke City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

4 years

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution?.....

3. (a) FULL NAME

Nancy Lee Custis

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Widowed

6. (b) Name of husband or wife

Luther Custis

7. Birth date of deceased (mo., day, yr.)

October 4, 1874

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Parksley, Accomac, Va.

(town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

William S. Hinman

FATHER

Virginia

MOTHER

Mary C. Wessells

MOTHER FATHER

Virginia

16. Informant.....

Harry J. Custis

Address

Locomoke City, Md.

17. Burial.....

Burial

Date thereof Jan. 6, 1948
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Yellow Cemetery

Location.....

Rural Locomoke

18. Funeral director.....

Henry S. Wilson

Address.....

Locomoke, Md.

19. Date rec'd by registrar

Jan. 6, 1947

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

City or town.....

Rural Locomoke City

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

✓

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

January 4, 1948, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 4, 1948, to Jan. 4, 1948,

and that I last saw her alive on Jan. 3, 1948.

Immediate cause of death.....

Intracardial degeneration 1 year

Atherosclerosis 2 years

Due to: Change of habit 2 years

Pneumonia 3 days

Due to: _____

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed. Jan. 6, 1948

RECORDED

JAN 7 1948

BURKE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01025

351

CERTIFICATE OF DEATH

131a
Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day
80 9 14 hrs. min.

8. Birthplace

(Town, county, and state)

10. Usual occupation.

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (date) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

19. Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1948 at 6:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 23 1948 to January 24 1948

and that I last saw him alive on January 23 1948 1948

Immediate cause of death

Respiratory paralysis

DURATION

2 Hrs.

Due to cerebral vascular accident

3 days

Due to hypertension, arteriosclerosis

10 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE Robert La May, MD

M. D. or other

Address Granfield Date signed 1-24-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01026

Reg. Dist. No.

355

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

Worcester

City or town.....

Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

55 years

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Howard H. Dill

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

married

6.(b) Name of husband or wife

Mary F. Dill

7. Birth date of deceased (mo., day, yr.)

June 30, 1889

8. AGE:

Years

Months

Days

If less than one day

58

6

1

hrs.

min.

9. Birthplace

Huntington Md

(Town, county, and state)

10. Usual occupation

mechanic, Barber

11. Industry or business

Retired

FATHER

12. Name

Deykah Dill

13. Birthplace

Md

14. Maiden name

Sally Dunning

15. Birthplace

Easton MD

16. Informant

Mrs. H. H. Dill

Address

Berlin Md

17. Burial

Date thereof.....

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Buckingham

Cemetery or crematory

Berlin Md

Location

Burke A Burleigh

18. Funeral director

Burke A Burleigh

Address

Berlin Md

19. I - 2

19-49

(Date rec'd by registrar)

Helen S. Hayward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Worcester

City or town.....

Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

1

(If rural, give LOCATION)

2.(a) If veteran, name war.....

World War I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 1 1948 at 2:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 Jan 1948 to 1 Jan 1948

and that I last saw him alive on 1 Jan 1948

Immediate cause of death.....

Acute Coronary Thrombosis
C Pulmonary Edema

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

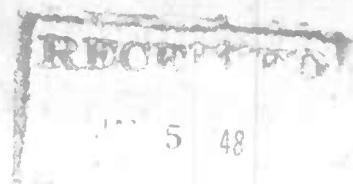
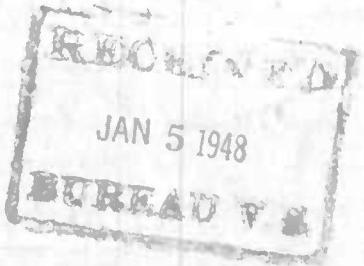
Means of injury.....

Injured at work?

23. SIGNATURE

H. A. Dill 2/5 M. D. or other

Address: 507 S. Berlin, Md Date signed: 2 Jan 48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01627

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: *1307 Bon Road 1 1/2 miles
N E of Geraleine 6 mos.*

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

3. (a) FULL NAME

4. Sex

2

5. Color or race

C.

6. (a) Single, married, widowed, or divorced

S.

6 (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 19, 1932

6 (c) If alive, give age years

8. AGE:

Years
*15*Months
*7*Days
26

It less than one day

hrs.
min.

9. Birthplace Newark, Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Elysl Foreman

13. Birthplace MD

14. Maiden name Annie May Debissay

15. Birthplace NC

16. Informant Elysl Foreman

Address

Newark MD

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 1/18/48

(month) (day) (year)

Cemetery or crematory Cedar Chapel

Location Newark MD R 2 D.

18. Funeral director Dennis A Burbage

Address Berlin MD

19. (Date rec'd by registrar) 1/19/48

Registrator L. E. Day Smith

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Ward No.

Street No.

(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15, 1948, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Jan 15, 1948

Immediate cause of death

Virus Pneumonia

Due to

Due to

Other condition Acute Indigestion

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Pneumonia

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

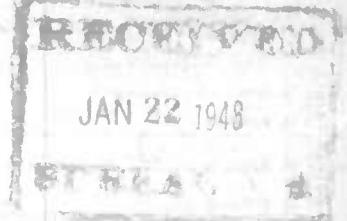
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

T. J. Santorius M.D.

Poconos City, PA Date signed 1/16/48

Address



Verbal permit by
phone to A.A. Burbaq
11/14 8 P.M. due to de-
layed death certif.

Lafay Smit
L.Reg. 351

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01028

CERTIFICATE OF DEATH

93d
Reg. Dist. No.

355

1. PLACE OF DEATH:

County.....

Worcester

City or town.....

Rural Berlin Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

20 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Emma C. Johnson

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female White Widower

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

May 29, 1870

8. (c) If alive, give age..... years

8. AGE:

Years Months Days If less than one day

77 7 25 hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

Merchant

11. Industry or business

12. Name..... Emma C. Johnson

13. Birthplace..... Delaware

14. Maiden name..... Mary E. Hudson

15. Birthplace..... Delaware

16. Informant..... Henry C. Johnson

Address..... 1875 S. High St. Del.

17. Burial..... Date thereof..... June 27, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Johnson Cemetery

Location..... 1875 S. High St. Del. P.D. #1

18. Funeral director..... Henry N. Watson

Address..... Worcester Md.

19. 1/25 1948
(Date rec'd by registrar) Helen Hayward
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

24 Jan 1948 at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

24 Jan 1948 to 24 Jan 1948

and that I last saw her alive on 24 Jan 1948

Immediate cause of death.....

Acute Convulsions
Strangulation

DURATION

Due to..... Chronic Degeneration

Myocarditis

10 min

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... H. Johnson

M. D. or other

Address..... 5 Bay St. Berlin Date signed 25 Jan 1948

RECORDED

JAN 27 1948

SURVEY



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01023

CERTIFICATE OF DEATH

4815
Reg. Dist. No. 350

1. PLACE OF DEATH:

County Worcester

City or town Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

5 weeks

How long in above place of death?

Hospital, institution, or street address where death occurred:

413 Market St.

How long in hospital or institution?

11111

3.(a) FULL NAME

SARAH BLANCHE MOORE

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

B. Frazier Moore

Deceased

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

January 15, 1874

8. AGE:

Years
74Months
0Days
6

If less than one day

hrs.
.....min.
.....

9. Birthplace

Crisfield-Somerset-Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

MOTHER FATHER

12. Name

John P. Tawes

13. Birthplace

Crisfield, Md.

14. Maiden name

Mary Susan White

15. Birthplace

Matthews County, Va.

16. Informant

Mrs. Roberta Callahan

Address

Pocomoke City, Md.

17. Burial

Date thereof

Jan 23, 1948
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Sunny Ridge Memorial

Cemetery or crematory

Hopewell, Crisfield, Md.

Location

H. Harvey Bradshaw

18. Funeral director

Crisfield, Md.

Address

Jan. 23, 1948
(Date rec'd by registrar)Anne E. White
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Somerset

City or town Crisfield

(If outside city or town limits, write RURAL and give nearest town)

Street No. 301 Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 23, 1948, at 9:55 AM

I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10, 1948, to Jan 23, 1948,

and that I last saw deceased alive on Jan 20, 1948.

Immediate cause of death

Disease of heart
to death

DURATION

6900

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

C. E. Gaither, M.D.
Anne E. White, Registrar
Date signed, 1948

M. D. or other

JAN 26 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct ink. Especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01030

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County..... Worcester
City or town..... Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

724 6th St.

How long in hospital or institution? //

3. (a) FULL NAME

LILLIE J. PARSONS

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Colored Married

6.(b) Name of husband or wife..... George Parsons

7. Birth date of deceased (mo. day. yr.) 6.(c) If alive, give age 60 years
September 1, 18988. AGE: Years Months Daye It less than one day
✓58 4 24 hrs. min.9. Birthplace..... Pocomoke-Worcester-Md
(Town, county, and state)

10. Usual occupation..... Domestic

11. Industry or business..... Housework

12. Name..... James H. Fisher

13. Birthplace..... Worcester Co., Md.

14. Maiden name..... Cora Sturgis

15. Birthplace..... Worcester Co., Md.

16. Informant..... George Parsons

Address..... Pocomoke City, Md.

17. Burial Date thereof Jan 29, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Halls Hill Cemetery

Location..... Pocomoke City, Md.

18. Funeral director..... H. Harvey Bradshaw

Address..... Pocomoke City, Md.

19. Date rec'd by Registrar..... Jan 29, 1948
(Date rec'd by Registrar) Anne E. White
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Worcester

City or town..... Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 724 6th St.

(If rural, give LOCATION)

2.(a) If veteran, name war..... //

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 29, 1948 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1947 to Jan 29, 1948
and that I last saw her alive on Jan 25, 1948

Immediate cause of death..... Chronic nephritis

DURATION

1 year

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed..... Jan 29, 1948

RECEIVED

JAN 31 1948

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01031

CERTIFICATE OF DEATH

351

Reg. Dist. No.

1. PLACE OF DEATH

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

1 month

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Rose M. Carter

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

July 4 - 1870

6. (c) If alive, give age..... years

8. AGE:

Years Months Days If less than one day

77

15

hrs. min.

9. Birthplace.....

(Town, county, and state) Snow Hill, Worcester, Md

10. Usual occupation.....

Housewife

11. Industry or business.....

Own home

12. Name.....

George M. Carter

13. Birthplace.....

Maryland

14. Maiden name.....

Jaditha Blader

15. Birthplace.....

Maryland

16. Informant.....

Mrs Marion Dornan

Address.....

Snow Hill, Md

17. Burial, cremation, or removal (which?)

Burial Date thereof Jan 21/48

(month) (day) (year)

Cemetery or crematory.....

Whitcoat Methodist

Location.....

Snow Hill, Md

18. Funeral director.....

Clay C. Dennis

Address.....

Snow Hill, Md

19. (Date rec'd by registrar)

1/21/48

1948

LeRoy Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City of town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

NO

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 19 1948 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1946 to Jan 19 1948

and that I last saw her alive on Jan 18 1948

Immediate cause of death..... Bronchopneumonia

and gangrene left leg

DURATION 1 day

Due to..... Cerebral apoplexy with

hemiplegia - due to

Due to..... arteriosclerosis

6 mo unknown

Other conditions..... Diabetes mellitus

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

Paul Rey M. D. Registrar

Address..... Snow Hill Date signed Jan 21, 1948

RECORDED

JAN 24 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01032

CERTIFICATE OF DEATH

Reg. Dist. No. 350

93d

1. PLACE OF DEATH:

County

City or town

Worcester
Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

72 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male. White Married

6. (b) Name of husband or wife

Mrs Ruth Powell

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.)

September 2-1875

8. AGE: Years Months Days If less than one day

9. Birthplace

Pocomoke, Worcester Md.

(Town, county, and state)

10. Usual occupation

Solicitor for Sev. Chancery

11. Industry or business

Dry Goods

12. Name

Levell Powell

13. Birthplace

Maryland

14. Maiden name

Alice Ball

15. Birthplace

Virginia

16. Informant

Mrs Ruth Powell

Address

Pocomoke Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan 8-1948

(month) (day) (year)

Cemetery or crematory

Presbyterian Cemetery

Location

Pocomoke Md.

18. Funeral director

J. W. Johnson

Address

Pocomoke Md.

19. Jan. 8 1948

Date rec'd by registrar

Anne E. White

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

Maryland County Worcester

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. Market Street (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

313-05-7068

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1948 at 3:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 to 1948 and that I last saw him alive on Jan 5 1948.

Immediate cause of death

Myocardial degeneration 4 years DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

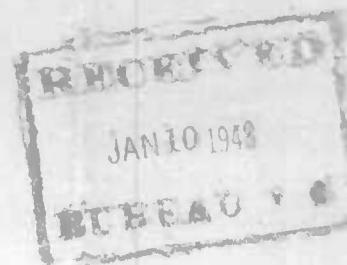
Injured at work

23. SIGNATURE

M. D. or other

Address

Date signed Jan 8 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In connect age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 01033

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH

County

City or town

Worcester

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

16 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Thomas P. Selby

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Emma Selby

6. (c) If alive, give age

years

7. Birth date of deceased (mo. day, yr.)

Oct. 3 - 1861

8. AGE: Years Months Days If less than one day

84 10 28 hrs. min.

8. (c) If alive, give age

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